

**Testimony of  
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Good afternoon Commissioner Daines, Superintendent Dinallo, Assistant Deputy Secretary Baker, and distinguished hearing officers. My name is Dr. Karen Morice, and I am here today in my role as Vice President of SEIU Healthcare's Committee of Interns and Residents, the nation's largest physician union. I am also a resident physician at St. Vincent's Hospital Manhattan. Thank you for this opportunity to share my experience, as a doctor and frontline healthcare provider, on the need for access to quality healthcare for all New Yorkers.

There are approximately 2.5 million uninsured New Yorkers. That means there are too many unmet medical needs and preventable tragedies occurring every day in our city. From my colleagues in the Emergency Room I hear about children who come in gasping for breath when they should be managing their asthma in a more rational, less traumatic fashion. I hear about early deaths that could easily have been prevented with regular checkups, mammograms, pap smears and other *very* inexpensive but life-saving early warning tests.

By the time an uninsured patient presents in the ER, it is sometimes much too late. Not only have they suffered terribly, but it is now too late to stop the course of a fourth-stage, metastasized cancer, for example, despite the very expensive treatments we will give them. Emergency Rooms nationwide are stretched to the breaking point, and bearing the brunt of the uninsured – in extra-long wait times, and unrecoverable financial strain.

My specialty is Physical Medicine and Rehabilitation, working with people with all kinds of disabilities, including patients with strokes, arthritis, and lower back pain. We help patients to walk again, or regain use of a hand, or return as closely as possible to the kind of life they were leading before an accident. Luckily for the surrounding community, St. Vincent's does provide Rehab treatment to the uninsured in outpatient clinics, and in consultations in the hospital.

But our hospital, like many others throughout New York, has experienced financial strain – we recently emerged from bankruptcy – and the high cost of caring for the uninsured is one of the stressors on our system.

I would also like to address the irrationality in our current system. As doctors, we would like to treat patients in a rational manner, based on their medical needs. But as our healthcare system is currently configured, we find ourselves mindful that our treatment depends upon whether they are insured, and if so, what type of coverage they have. This issue of coverage impacts on treatment, billing, doctor's notes and progress reports. It is not uncommon for patients to find themselves unable to access treatment and medications that are essential to their condition.

I would like to share some of my experiences, and my colleagues' with you. A Primary Care physician in the city is currently treating an elderly patient covered by Medicare who has multiple medical problems. Although she has a prescription plan, because of the number of prescriptions she needs and the fixed income she lives on, she can't afford many of her medications. The physician is treating her for diabetes and high blood pressure. Whenever she comes in, the doctor gives her free samples of whatever medication is on hand. When she comes back for her regular appointment, she has run out of the free samples, her blood pressure is in the 200s, and her sugars are also through the roof. She gets whatever free samples they have, which are once again different medications, and now she's confused about what she's supposed to take, and what the dosage is.

A surgeon in our hospital treats patients with vascular disease of the legs by putting in a stent, which opens up the arteries, much like stents used in the arteries of the heart. You need a particular type of medication – usually Plavix, which is expensive, and not covered on all plans. The patient can't afford it, but without the Plavix, he comes back and his legs are now clogged up again. He ends up with pain and ischemia, not enough oxygen going to his legs. He may end up losing his legs -- and he is not the only patient in this sorry situation.

In one of our Rehab clinics, we had a patient with pain, and treatment kept getting delayed because his insurance was a managed Medicaid so he needed pre-authorization before anything could be done. One of our attending physicians saw the patient at a reduced rate and treated him with osteopathic manipulation, and the treatment was helpful, but because it was not authorized or reimbursed, the patient couldn't continue treatment. We tried other therapies in the clinic, but no other treatment helped.

You may think that as physicians we are immune to the problems of irrationality in our healthcare system. We are not! Even those of us with so-called "good" insurance can run into problems. One of my former colleagues, now an attending physician at a Long Island hospital, had problems with his coverage. While he was a resident doctor at my hospital, he had a tumor in his leg, and had several reconstructive surgeries. Our insurance didn't cover many things, and he ended up having to give himself IV antibiotics at home for months. His insurance at his new job is claiming that this is a "pre-existing condition" and won't pay for the surgery that could best treat his condition.

So he's considering amputating. The hospital he works at will give him a discount on the amputation, but he would have to go to different hospital for the corrective surgery, and there isn't enough coverage for that. What could be more irrational than losing a foot and part of a leg unnecessarily?

When our hospital switched insurers for its employees, I found myself unable to get the medication I had been using. I had to speak with a supervisor at the insurance company, and then file a grievance in order to get it covered, and it's a very basic medication. It helps being a doctor – not everyone is able to advocate as effectively for themselves.

As resident physicians, we are each acutely aware of what is going on in our own departments, and in our hospital. Over the course of my residency, my union, the Committee of Interns and Residents, has helped expose me to a broader view of healthcare policy issues in New York.

I joined in the *Save Our Safety Net* rallies and legislative visits, which focused on keeping healthcare accessible to underserved communities. Our goals were to maintain access to quality care for those patients and communities in need. We know that the finances of many hospitals are fragile – and without those hospitals, there will be less care for chronic and emergent conditions in the surrounding neighborhoods.

With CIR, we have testified at rallies, signed petitions and spoken with our legislators in favor of expanding funding for SCHIP, the federally funded State Children's Health Insurance Program. It is hard to imagine a less-controversial program than one which provides healthcare to uninsured children. Despite not being able to sustain an override of the President's veto, we remain committed to the goals of this critical program, and will continue to work to find ways to provide coverage for all children, and for all residents of NY State who need it.

Our goal is to expand access to care, and every step in the right direction, that gets more people covered, is the direction we want to go in. Personally, I like the idea of Medicare for All. It is a uniquely American approach, something we are familiar with, and have seen working successfully. I think it could provide a good model for how to go about expanding coverage.

Thank you for this opportunity to share my experience as a healthcare provider. I am glad that Governor Spitzer and the New York State Departments of Health and Insurance are looking for ways to improve access to healthcare for all New Yorkers.